Reprinted
March 23, 2005

ENGROSSED
SENATE BILL No. 615

DIGEST OF SB 615 (Updated March 22, 2005 6:38 pm - DI 104)

Citations Affected: IC 12-10; noncode.

Synopsis: CHOICE board. Adds additional members to, and additional duties for, the community and home options to institutional care for the elderly and disabled (CHOICE) board. Extends certain expiration dates. Requires the office of Medicaid policy and planning to adopt rules concerning specified matters concerning the supported living program and reimbursement system. Requires the division of disability, aging, and rehabilitative services to adopt rules concerning: (1) provider standards; (2) audits, (3) the development of a comprehensive bureau of developmental disabilities services provider manual; (4) definitions of services; (5) documentation standards; and (6) training. Requires the office of the secretary to adopt rules: (1) governing fiscal audits; and (2) auditing rules for providers of services to developmentally disabled individuals.

Effective: Upon passage; 71, 2005; July 1, 2005.

Server, Broden, Zakas, Long
(HOUSE SPONSORS — BECKER, BROWN C, THOMAS)

January 24, 2005, read first time and referred to Committee on Health and Provider Services.
February 3, 2005, amended, reported favorably — Do Pass.
February 7, 2005, read second time, ordered engrossed.
February 8, 2005, engrossed. Read third time, passed. Yeas 47, nays 1.

HOUSE ACTION

March 8, 2005, read first time and referred to Committee on Public Health.
March 17, 2005, amended, reported — Do Pass.
March 22, 2005, read second time, amended, ordered engrossed.

Reprinted
March 23, 2005

First Regular Session 114th General Assembly (2005)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2004 Regular Session of the General Assembly.

ENGROSSED
SENATE BILL No. 615

A BILL FOR AN ACT to amend the Indiana Code concerning human services.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 12-10-11-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 2. (a) The board consists of the following ~~nine (9)~~ **fifteen (15)** members:

(1) The director of the division of family and children or the director's designee.

(2) The chairman of the Indiana state commission on aging or the chairman's designee.

(3) ~~Two (2)~~ **Three (3)** citizens at least sixty (60) years of age, nominated by ~~one (1)~~ **two (2)** or more organizations that:

(A) represent senior citizens; and

(B) have statewide membership.

(4) One (1) citizen less than sixty (60) years of age nominated by one (1) or more organizations that:

(A) represent individuals with disabilities; and

(B) have statewide membership.

(5) One (1) citizen less than sixty (60) years of age nominated by one (1) or more organizations that:

(A) represent individuals with mental illness; and

(B) have statewide membership.

(6) One (1) provider who provides services under IC 12-10-10.

(7) One (1) licensed physician, nurse, or nurse practitioner who specializes either in the field of gerontology or in the field of disabilities.

(8) ~~One (1)~~ **Two (2)** home care services ~~advocate~~ **advocates** or policy ~~specialist~~ **specialists** nominated by ~~one (1)~~ **two (2)** or more:

(A) organizations;

(B) associations; or

(C) nongovernmental agencies;

that advocate on behalf of home care consumers, **including an organization listed in subdivision (3) that represents senior citizens or persons with disabilities.**

(9) Two (2) members of the senate who may not be members of the same political party, appointed by the president pro tempore of the senate with the advice of the minority leader of the senate.

(10) Two (2) members of the house of representatives, who may not be members of the same political party, appointed by the speaker of the house of representatives with the advice of the minority leader of the house of representatives.

The members of the board listed in subdivisions (9) and (10) are nonvoting members.

(b) The members of the board designated by subsection (a)(3) through (a)(8) shall be appointed by the governor for terms of two (2) years. In case of a vacancy, the governor shall appoint an individual to serve for the remainder of the unexpired term.

(c) The division shall establish notice and selection procedures to notify the public of the board's nomination process described in this chapter. Information must be distributed through:

(1) the area agencies on aging; and

(2) all organizations, associations, and nongovernmental agencies that work with the division on home care issues and programs.

SECTION 2. IC 12-10-11-8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 8. The board shall do the following:

(1) Establish long term goals of the state for the provision of a continuum of care for the elderly and disabled based on the following:

(A) Individual independence, dignity, and privacy.

(B) Long term care services that are:
(i) integrated, accessible, and responsible; and
(ii) available in home and community settings.
(C) Individual choice in planning and managing long term care.
(D) Access to an array of long term care services:
(i) for an individual to receive care that is appropriate for the individual's needs; and
(ii) to enable a case manager to have cost effective alternatives available in the construction of care plans and the delivery of services.
(E) Long term care services that include home care, community based services, assisted living, congregate care, adult foster care, and institutional care.
(F) Maintaining an individual's dignity and self-reliance to protect the fiscal interests of both taxpayers and the state.
(G) Long term care services that are fiscally sound.

(2) Review state policies on community and home care services.

(3) Recommend the adoption of rules under IC 4-22-2.

(4) Recommend legislative changes affecting community and home care services.

(5) Recommend the coordination of the board's activities with the activities of other boards and state agencies concerned with community and home care services.

(6) Evaluate cost effectiveness, quality, scope, and feasibility of a state administered system of community and home care services.

(7) Evaluate programs for financing services to those in need of a continuum of care.

(8) Evaluate state expenditures for community and home care services, taking into account efficiency, consumer choice, competition, and equal access to providers.

(9) Develop policies that support the participation of families and volunteers in meeting the long term care needs of individuals.

(10) Encourage the development of funding for a continuum of care from private resources, including insurance.

(11) Develop a cost of services basis and a program of cost reimbursement for those persons who can pay all or a part of the cost of the services rendered. The division shall use this cost of services basis and program of cost reimbursement in administering IC 12-10-10. The cost of services basis and program of cost reimbursement must include a client cost share

formula that:

(A) imposes no charges for an eligible individual whose income does not exceed one hundred fifty percent (150%) of the federal income poverty level; and

(B) does not impose charges for the total cost of services provided to an individual under the community and home options to institutional care for the elderly and disabled program unless the eligible individual's income exceeds three hundred fifty percent (350%) of the federal income poverty level.

The calculation of income for an eligible individual must include the deduction of the individual's medical expenses and the medical expenses of the individual's spouse and dependent children who reside in the eligible individual's household.

(12) Establish long term goals for the provision of guardianship services for adults.

(13) Coordinate activities and programs with the activities of other boards and state agencies concerning the provision of guardianship services.

(14) Recommend statutory changes affecting the guardianship of indigent adults.

(15) Review a proposed rule concerning home and community based services as required under section 9 of this chapter.

SECTION 3. IC 12-10-11-9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 9. (a) The board shall be given the opportunity to review a proposed rule concerning home and community based services for:**

(1) elderly individuals; or

(2) individuals with disabilities;

at least three (3) months before a proposed rule may be published in the Indiana Register.

(b) If the proposing agency fails to give the board the opportunity to review a proposed rule described in subsection (a), the rule:

(1) is void; and

(2) must be withdrawn by the proposing agency.

(c) The board may determine that the proposed rule reviewed by the board under this section should be subject to a public comment period. If the board makes a determination that a public comment period is necessary, the board shall set the:

(1) date and time;

(2) location; and

(3) format;

of the public comment period for the proposed rule.

(d) After a public hearing, if the board determines that a proposed rule is substantially out of compliance with state law governing home and community based services, the board shall request that the agency proposing the rule modify or withdraw the proposed rule. If a proposed rule is modified under this subsection, the modified rule must be reviewed by the board.

SECTION 4. P.L.274-2003, SECTION 7, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: SECTION 7. (a) As used in this SECTION, "board" refers to the community and home options to institutional care for the elderly and disabled board established by IC 12-10-11-1.

(b) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.

(c) As used in this SECTION, "waiver" refers to the aged and disabled Medicaid waiver.

(d) Before September 1, 2003, the office shall discuss and review any amendment to the waiver required under this SECTION with the board.

(e) Before October 1, ~~2003,~~ **2005,** the office shall apply to the United States Department of Health and Human Services to amend the waiver to include in the waiver any service that is offered under the community and home options to institutional care for the elderly and disabled (CHOICE) program established by IC 12-10-10-6. A service provided under this subsection may not be more restrictive than the corresponding service provided under IC 12-10-10.

(f) The office may not implement the waiver until the office files an affidavit with the governor attesting that the amendment to the waiver applied for under this SECTION is in effect. The office shall file the affidavit under this subsection not later than five (5) days after the office is notified that the waiver is approved.

(g) If the office receives approval for the amendment to the waiver under this SECTION from the United States Department of Health and Human Services and the governor receives the affidavit filed under subsection (f), the office shall implement the waiver not more than sixty (60) days after the governor receives the affidavit.

(h) Before January 1, ~~2004,~~ **2006,** the office shall meet with the board to discuss any changes to other state Medicaid waivers that are necessary to provide services that may not be more restrictive than the services provided under the CHOICE program. The office shall

recommend the changes determined necessary by this subsection to the governor.

(i) The office may adopt rules under IC 4-22-2 necessary to implement this SECTION.

(j) This SECTION expires July 1, ~~2008.~~ **2010.**

SECTION 5. P.L.274-2003, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: SECTION 8. (a) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.

(b) As used in this SECTION, "waiver" refers to a Medicaid waiver approved by the United States Department of Health and Human Services (42 U.S.C. 1396 et seq.).

(c) Before September 1, ~~2003,~~ **2005,** the office shall seek approval from the United States Department of Health and Human Services to amend the waiver to modify income eligibility requirements to include spousal impoverishment protection provisions under 42 U.S.C. 1396r-5 that are at least at the level of the spousal impoverishment protections afforded to individuals who reside in health facilities licensed under IC 16-28. The office also shall seek approval for twenty thousand (20,000) additional waiver slots at no additional cost to the state.

(d) The office may not implement the waiver amendments until the office files an affidavit with the governor attesting that the federal waiver amendment applied for under this SECTION is in effect. The office shall file the affidavit under this subsection not later than five (5) days after the office is notified that the waiver amendment is approved.

(e) If the United States Department of Health and Human Services approves the waiver amendment requested under this SECTION and the governor receives the affidavit filed under subsection (d), the office shall implement the waiver amendments not more than sixty (60) days after the governor receives the affidavit.

(f) The office may adopt rules under IC 4-22-2 necessary to implement this SECTION.

(g) This SECTION expires July 1, ~~2008.~~ **2010.**

SECTION 6. P.L.274-2003, SECTION 10, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: SECTION 10. (a) As used in this SECTION, "office" refers to the office of the secretary of family and social services established by IC 12-8-1-1.

(b) Before July 1, ~~2004,~~ **2006,** the office shall have self-directed care options services available for:

(1) the community and home options to institutional care for the elderly and disabled program established by IC 12-10-10-6; and

(2) a Medicaid waiver;

for an eligible individual who chooses self-directed care services.

(c) This SECTION expires December 31, ~~2006.~~ **2008.**

SECTION 7. P.L.274-2003, SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: SECTION 12. (a) Before December 31, ~~2003,~~ **2005,** the secretary of family and social services (IC 12-8-1-2) shall discuss with the community and home options to institutional care for the elderly and disabled (CHOICE) board established by IC 12-10-11-1, and with any other agency, volunteer, volunteer group, faith based group, or individual that the secretary considers appropriate, the establishment of a system of integrated services, including:

(1) transportation;

(2) housing;

(3) education; and

(4) workforce development;

to enhance the viability and availability of home and community based care.

(b) The secretary shall report to the governor and the budget committee any recommendations for funding these services.

(c) This SECTION expires December 31, ~~2004.~~ **2006.**

SECTION 8. P.L.274-2003, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: SECTION 14. (a) Beginning July 1, 2003, the office of Medicaid policy and planning shall implement a policy that allows the amount of Medicaid funds necessary to provide for services to follow an individual who is transferring from institutional care to Medicaid home and community based care. The amount may not exceed the amount that would have been spent on the individual if the individual had stayed in institutional care.

(b) This SECTION expires July 1, ~~2005.~~ **2007.**

SECTION 9. [EFFECTIVE JULY 1, 2005] **(a) Before July 1, 2006, the office of Medicaid policy and planning shall adopt rules under IC 4-22-2 that define the criteria and process used by the office of Medicaid policy and planning to determine if a developmentally disabled individual (as defined in IC 12-7-2-62) qualifies for the level of care provided by an intermediate care facility for the mentally retarded (ICF/MR). The rules must provide that a developmentally disabled individual (as defined in IC 12-7-2-62) qualifies for the level of care for an intermediate care facility for the mentally retarded (ICF/MR) if the individual's disability results in substantial functional limitations in at least three (3) of the following areas of major life activities:**

(1) Self-care.

(2) Understanding and use of language.

(3) Learning.

(4) Mobility.

(5) Self-direction.

(6) Capacity for independent living.

(b) Before July 1, 2006, the office of Medicaid policy and planning shall adopt rules under IC 4-22-2 that define the criteria and process used by the office of Medicaid policy and planning to determine the number of hours of care that a developmentally disabled individual (as defined in IC 12-7-2-62) needs in a supervised group living setting. The rules must provide that a developmentally disabled individual (as defined in IC 12-7-2-62) in the following types of supervised group living settings needs the following hours of care per resident day:

(1) Intensive training, six (6) hours.

(2) Developmental training, eight (8) hours.

(3) Basic development, ten (10) hours.

(4) Medically fragile, twelve (12) hours.

(5) Child rearing, eight (8) hours.

(6) Child rearing with specialized programs, ten (10) hours.

(7) Small residence with behavior management for children, twelve (12) hours.

(c) Before July 1, 2006, the office of Medicaid policy and planning shall adopt rules under IC 4-22-2 to amend the requirements under 405 IAC to require that the supported living program and reimbursement system contain the following components:

(1) Conduct of an independent assessment to determine the level of resources necessary to meet the needs of a developmentally disabled individual (as defined in IC 12-7-2-62) in a healthy and safe environment.

(2) Determination of the level of resources that are needed by a developmentally disabled individual (as defined in IC 12-7-2-62) using a funding matrix that differentiates between needs and service requirements for developmentally disabled individuals:

(A) with family or other nonpaid supports; and

(B) without family or other nonpaid supports.

(3) Requirement that individual support teams assist developmentally disabled individuals (as defined in IC 12-7-2-62) in developing and implementing individualized

plans after resources have been allocated.

(4) Require daily rate components for individuals enrolled in services that include components for residential services (based on at least a three (3) resident to one (1) staff ratio, whenever possible), day services, and other services as determined by the division of disability, aging and rehabilitative services.

(5) Require an annual or biennial service agreement among the state, provider and developmentally disabled individual (as defined in IC 12-7-2-62) formalizing the commitment of each party to the placement and implementation of the individualized support plan.

(6) Allow termination or modification of the service agreement if:

(A) the individual is not in services for more than fifteen (15) consecutive days;

(B) the services described in the individualized support plan have not been provided;

(C) the individual is abused or neglected by an agent or employee of the provider during the period of the service agreement;

(D) there is a substantial change in the condition of the individual which increases the total services required by the individual;

(E) through no fault of the provider, a housemate departs the setting; or

(F) the provider fails to provide reports and information as requested by the state.

(7) Require annual cost reporting to determine the base rates for the funding matrix under subdivision (2).

(d) This SECTION expires July 1, 2007.

SECTION 10. [EFFECTIVE JULY 1, 2005] **(a) Before July 1, 2006, the division of disability, aging, and rehabilitative services shall adopt rules under IC 4-22-2 to amend 460 IAC 6 to:**

(1) allow a provider to be given credit for any provider standards that the division determines are the same as or similar in intent and effect as state or federally mandated provider standards;

(2) require a provider to comply with any individual provider standards not included in the accreditation standards of an approved independent national accreditation organization;

(3) require a provider or approved independent national

accreditation organization to provide the division with documentation of the applicable accreditation standards; and

(4) require the provider to maintain accreditation and notify the division if accreditation is suspended or revoked.

(b) This SECTION expires July 1, 2007.

SECTION 11. [EFFECTIVE JULY1, 2005] **(a) Before July 1, 2006, the office of the secretary of family and social services shall adopt rules under IC 4-22-2 to add and amend rules under 405 IAC to govern fiscal audits completed by:**

(1) the office of the secretary of family and social services audit staff; and

(2) agencies contracted by the office of the secretary of family and social services to complete fiscal audits.

(b) Before July 1, 2006, the office of the secretary of family and social services shall adopt rules under IC 4-22-2 to add and amend rules under 405 IAC to require that the office of the secretary of family and social services' audit rules for providers of services to a developmentally disabled individual (as defined in IC 12-7-2-62) must meet the following requirements:

(1) All classifications of providers are required to be audited.

(2) The audit process must be written, formalized, and have specific time schedules.

(3) Not less than fourteen (14) days advanced notice must be given before:

(A) an audit; and

(B) any papers required to be provided during the audit must be submitted to the audit agency.

(4) The purpose and content of an exit conference must be defined.

(5) The purpose, scope, and schedule for the issuance of audit reports must be defined.

(6) Except for cases of fraud, an audit must be completed and issued not more than two (2) years after the end of the:

(A) grant period; or

(B) provider's fiscal year;

whichever is later.

(7) A formal appeal process that includes:

(A) the issuance of a preliminary finding;

(B) a time for the provider to respond to the preliminary findings and submit additional information for review before final findings are issued; and

(C) appeal procedures with deadlines.

(c) Before July 1, 2006, the division of disability, aging, and rehabilitative services shall adopt rules under IC 4-22-2 that comply with rules adopted under subsections (a) and (b) and that require the following:

(1) Audit and program staff of the family and social services administration to jointly approve issued service definitions and bulletins that impact potential audit issues.

(2) Development of comprehensive bureau of developmental disabilities services provider manual for state and waiver funded services that is comparable to the Medicaid provider manual.

(3) All revisions to the manual created under subdivision (2) and rules adopted or amended may be implemented only on the first day of a month.

(4) Develop consistent definitions of services and documentation standards regardless of the funding source.

(5) Develop written documentation standards, including acceptable electronic documentation formats.

(6) Provide initial and periodic training of a provider's financial staff by the division of disability, aging, and rehabilitative services concerning accounting, billing, and audit procedures.

(d) This SECTION expires July 1, 2007.

SECTION 12. **An emergency is declared for this act.**

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 615, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 1, delete lines 1 through 17.
Page 2, delete lines 1 through 5.
Page 2, line 14, delete "of the following".
Page 2, line 15, delete "organizations:" and insert "organizations".
Page 2, line 15, reset in roman "that:".
Page 2, reset in roman lines 16 through 17.
Page 2, delete lines 18 through 20.
Page 2, line 21, delete "(D) An organization that has".
Page 2, line 21, delete "that:".
Page 2, run in lines 17 through 21.
Page 2, delete lines 22 through 24.
Page 5, delete lines 38 through 42.
Delete pages 6 through 7.
Page 8, delete lines 1 through 9.
Page 10, delete lines 31 through 42.
Page 11, delete lines 1 through 19.
Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 615 as introduced.)

MILLER, Chairperson

Committee Vote: Yeas 10, Nays 0.

SENATE MOTION

Madam President: I move that Senator Long be added as coauthor of Engrossed Senate Bill 615.

SERVER

COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred Senate Bill 615, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 4, line 22, delete "long term care" and insert "**home and community based**".

Page 4, line 27, delete "long term care" and insert "**home and community based**".

Page 4, line 40, after "(1)" insert "**date and**".

Page 7, between lines 28 and 29, begin a new paragraph and insert:

"SECTION 9. [EFFECTIVE JULY 1, 2005] **(a) Before July 1, 2006, the office of Medicaid policy and planning shall adopt rules under IC 4-22-2 that define the criteria and process used by the office of Medicaid policy and planning to determine if a developmentally disabled individual (as defined in IC 12-7-2-62) qualifies for the level of care provided by an intermediate care facility for the mentally retarded (ICF/MR). The rules must provide that a developmentally disabled individual (as defined in IC 12-7-2-62) qualifies for the level of care for an intermediate care facility for the mentally retarded (ICF/MR) if the individual's disability results in substantial functional limitations in at least three (3) of the following areas of major life activities:**

(1) Self-care.

(2) Understanding and use of language.

(3) Learning.

(4) Mobility.

(5) Self-direction.

(6) Capacity for independent living.

(b) Before July 1, 2006, the office of Medicaid policy and planning shall adopt rules under IC 4-22-2 that define the criteria and process used by the office of Medicaid policy and planning to determine the number of hours of care that a developmentally disabled individual (as defined in IC 12-7-2-62) needs in a supervised group living setting. The rules must provide that a developmentally disabled individual (as defined in IC 12-7-2-62) in the following types of supervised group living settings needs the following hours of care per resident day:

(1) Intensive training, six (6) hours.

(2) Developmental training, eight (8) hours.

(3) Basic development, ten (10) hours.

(4) Medically fragile, twelve (12) hours.

(5) Child rearing, eight (8) hours.

(6) Child rearing with specialized programs, ten (10) hours.

(7) Small residence with behavior management for children, twelve (12) hours.

(c) Before July 1, 2006, the office of Medicaid policy and planning shall adopt rules under IC 4-22-2 to amend the requirements under 405 IAC to require that the supported living program and reimbursement system contain the following components:

(1) Conduct of an independent assessment to determine the level of resources necessary to meet the needs of a developmentally disabled individual (as defined in IC 12-7-2-62) in a healthy and safe environment.

(2) Determination of the level of resources that are needed by a developmentally disabled individual (as defined in IC 12-7-2-62) using a funding matrix that differentiates between needs and service requirements for developmentally disabled individuals:

(A) with family or other nonpaid supports; and

(B) without family or other nonpaid supports.

(3) Requirement that individual support teams assist developmentally disabled individuals (as defined in IC 12-7-2-62) in developing and implementing individualized plans after resources have been allocated.

(d) This SECTION expires July 1, 2007.

SECTION 10. [EFFECTIVE JULY 1, 2005] **(a) Before July 1, 2006, the division of disability, aging, and rehabilitative services shall adopt rules under IC 4-22-2 to amend 460 IAC 6 to provide that 460 IAC 6 does not apply to an agency that is accredited by one (1) of the following organizations:**

(1) The Commission on Accreditation of Rehabilitation Facilities (CARF) or its successor.

(2) The Council on Quality and Leadership in Supports for People with Disabilities or its successor.

(3) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or its successor.

(4) The National Commission on Quality Assurance or its successor.

(5) An independent national accreditation organization approved by the secretary.

(b) This SECTION expires July 1, 2007.".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 615 as printed February 4, 2005.)

BECKER, Chair

Committee Vote: yeas 11, nays 0.

HOUSE MOTION

Mr. Speaker: I move that Engrossed Senate Bill 615 be amended to read as follows:

Page 4, line 26, after "shall" insert "**be given the opportunity to**".

Page 4, line 32, delete "A" and insert "**If the proposing agency fails to give the board the opportunity to review a**".

Page 4, line 32, delete "that is not" and insert "**, the rule:**"

Page 4, delete line 33.

(Reference is to ESB 615 as printed March 18, 2005.)

BECKER

HOUSE MOTION

Mr. Speaker: I move that Engrossed Senate Bill 615 be amended to read as follows:

Page 8, between lines 41 and 42, begin a new line block indented and insert:

"**(4) Require daily rate components for individuals enrolled in services that include components for residential services (based on at least a three (3) resident to one (1) staff ratio, whenever possible), day services, and other services as determined by the division of disability, aging and rehabilitative services.**

(5) Require an annual or biennial service agreement among the state, provider and developmentally disabled individual (as defined in IC 12-7-2-62) formalizing the commitment of each party to the placement and implementation of the individualized support plan.

(6) Allow termination or modification of the service agreement if:

(A) the individual is not in services for more than fifteen (15) consecutive days;

(B) the services described in the individualized support plan have not been provided;

(C) the individual is abused or neglected by an agent or employee of the provider during the period of the service agreement;

(D) there is a substantial change in the condition of the individual which increases the total services required by

the individual;

(E) through no fault of the provider, a housemate departs the setting; or

(F) the provider fails to provide reports and information as requested by the state.

(7) Require annual cost reporting to determine the base rates for the funding matrix under subdivision (2).".

Page 9, line 3, delete "to provide" and insert "**to:**".

Page 9, delete lines 4 through 15, begin a new line block indented and insert:

"**(1) allow a provider to be given credit for any provider standards that the division determines are the same as or similar in intent and effect as state or federally mandated provider standards;**

(2) require a provider to comply with any individual provider standards not included in the accreditation standards of an approved independent national accreditation organization;

(3) require a provider or approved independent national accreditation organization to provide the division with documentation of the applicable accreditation standards; and

(4) require the provider to maintain accreditation and notify the division if accreditation is suspended or revoked.".

Page 9, between lines 16 and 17 begin a new line block indented and insert:

"SECTION 11. [EFFECTIVE JULY1, 2005] **(a) Before July 1, 2006, the office of the secretary of family and social services shall adopt rules under IC 4-22-2 to add and amend rules under 405 IAC to govern fiscal audits completed by:**

(1) the office of the secretary of family and social services audit staff; and

(2) agencies contracted by the office of the secretary of family and social services to complete fiscal audits.

(b) Before July 1, 2006, the office of the secretary of family and social services shall adopt rules under IC 4-22-2 to add and amend rules under 405 IAC to require that the office of the secretary of family and social services' audit rules for providers of services to a developmentally disabled individual (as defined in IC 12-7-2-62) must meet the following requirements:

(1) All classifications of providers are required to be audited.

(2) The audit process must be written, formalized, and have specific time schedules.

(3) Not less than fourteen (14) days advanced notice must be

given before:

(A) an audit; and

(B) any papers required to be provided during the audit must be submitted to the audit agency.

(4) The purpose and content of an exit conference must be defined.

(5) The purpose, scope, and schedule for the issuance of audit reports must be defined.

(6) Except for cases of fraud, an audit must be completed and issued not more than two (2) years after the end of the:

(A) grant period; or

(B) provider's fiscal year;

whichever is later.

(7) A formal appeal process that includes:

(A) the issuance of a preliminary finding;

(B) a time for the provider to respond to the preliminary findings and submit additional information for review before final findings are issued; and

(C) appeal procedures with deadlines.

(c) Before July 1, 2006, the division of disability, aging, and rehabilitative services shall adopt rules under IC 4-22-2 that comply with rules adopted under subsections (a) and (b) and that require the following:

(1) Audit and program staff of the family and social services administration to jointly approve issued service definitions and bulletins that impact potential audit issues.

(2) Development of comprehensive bureau of developmental disabilities services provider manual for state and waiver funded services that is comparable to the Medicaid provider manual.

(3) All revisions to the manual created under subdivision (2) and rules adopted or amended may be implemented only on the first day of a month.

(4) Develop consistent definitions of services and documentation standards regardless of the funding source.

(5) Develop written documentation standards, including acceptable electronic documentation formats.

(6) Provide initial and periodic training of a provider's financial staff by the division of disability, aging, and rehabilitative services concerning accounting, billing, and audit procedures.

(d) This SECTION expires July 1, 2007.".

Renumber all SECTIONS consecutively.

(Reference is to ESB 615 as printed March 18, 2005.)

BECKER